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No. 80-419

In the Supreme Court
OF THE
United States

OCTOBER TERM, 1980

STATE OF ARIZONA,

Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY, MARICOPA FOUNDATION FOR MEDICAL CARE, AND PIMA FOUNDATION FOR MEDICAL CARE,

Respondents.

JOINT BRIEF IN OPPOSITION TO THE STATE OF ARIZONA'S PETITION FOR A WRIT OF CERTIORARI

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RESTATEMENT OF QUESTION PRESENTED

On Petitioner's motion for partial summary judgment the undisputed facts established an agreement among the physicians who are members of a medical foundation that (1) each would charge his individual customary fee, but (2) with respect to patients covered by health insurance endorsed by that medical foundation each would accept as payment in full the amount paid by that insurance and not to try to recover from the patient any difference between the insurance payment and the fee billed if the fee was higher than the foundation's maximum level of reimbursement. Accordingly, it is submitted that the question presented must be restated as follows:

Did the Court of Appeals err in deciding the agreement among foundation member physicians was not properly characterized by Petitioner as horizontal "price-fixing" that is a *per se* violation of Section 1 of the Sherman Act and the action should proceed to trial to determine the economic effects of that agreement?

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JOINT BRIEF IN OPPOSITION TO THE STATE OF ARIZONA'S PETITION FOR A WRIT OF CERTIORARI

The Maricopa Foundation for Medical Care, the Pima Foundation for Medical Care and the Maricopa County Medical Society respectfully pray that this Court refuse to issue a writ of certiorari to review the decision of the United States Court of Appeals for the Ninth Circuit entered on March 20, 1980, as modified on April 28, 1980.

COUNTERSTATEMENT OF THE CASE

Petitioner's "Statement of the Case" distorts the record almost beyond recognition. This action does *not* involve an agreement by doctors on prices to charge their patients or circulation to doctors of schedules of fees to

be charged. Petitioner has attempted on a motion for partial summary judgment to affix conclusory, simplistic and misleading labels to a complex situation in an effort to condemn Respondents' conduct by characterizing it as a *per se* illegal horizontal price-fixing combination.

There is substantial dispute among the parties as to the "facts" upon which Petitioner has based its "Statement of the Case." It cites almost exclusively to Petitioner's "Statement of Undisputed Facts," CR 106. Despite the title of Petitioner's submission, each of the "undisputed facts" cited in the petition to this Court was disputed by one or more of the Respondents.[1] This action has not advanced beyond motions for summary judgment, discovery has not been completed and there has been no trial on the merits. Therefore the factual record is incomplete.

The Facts About the Respondents and the Conduct Petitioner Challenges

Contrary to Petitioner's assertion, it has failed to prove that there is a "fee schedule" as to what physicians bill or charge patients in this action.[2] The majority of the Ninth Circuit panel correctly perceived that "[t]he challenged conduct is the setting by majority vote of maximum fees that physician members may claim in full payment for health services they provide to policyholders of FMC-approved insurance plans."[3] The District Court found " the doctors who agree to participate in the

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[1]See CR 54 and 122.

[2]CR 122, paras. 37, 41.

[3]Pet. App. A at 2, CR 99 at 2.

foundation-approved plans are free to set the prices they charge their patients."[4]

Physician members of a foundation specifically agree that "participating membership in the foundation shall not affect the method of computation or amount of fees billed by me with respect to any medical care for any patient."[5] Foundation member physicians agree to accept as payment in full for patients covered by foundation endorsed insurance the *maximum* level of reimbursement from the insurer for services rendered if they bill *more* than that level (and are paid *less* than that level if they bill less).[6] What the member physician is paid by the foundation endorsed insurance may not fully compensate him for the services provided but he cannot collect any more from the covered patient. A foundation's use of defined dollar limits rather than a variable level based on usual and customary fees to determine maximum insurance reimbursement levels, which is attacked by Petitioner, is essential to the concept and operation of foundation insurance plans. The marketability of foundation endorsed health insurance depends in large part on consumers' desire to purchase a health plan such as foundation endorsed insurance which will pay 100% of physicians' charges for any given service.[7]

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[4]Pet. App. D at 39.

[5]CR 25, Exhibit A at para. 4, Affidavit of Anthony D. Mitten, sworn to November 17, 1978 ("Mitten Affidavit").

[6]CR 25, Mitten Affidavit, para. 4.

[7]Emergency Motion of Appellees Maricopa Foundation for Medical Care and Pima Foundation for Medical Care to Vacate Injunction and Dismiss Appeal and for Expedited Hearing and Accelerated Briefing, dated August 22, 1979, Affidavit of Lawrence Shapiro, sworn to August 22, 1979, para. 3.

A foundation only revises its maximum reimbursement levels when its Board of Trustees feels they have fallen so far below usual and customary fees that physicians will resign from or refuse to renew membership in the foundation if they are not revised. Revisions do not occur at any regular interval.[8] In the case of Maricopa Foundation, its Board of Trustees has never set a maximum reimbursement level in excess of what the Board believed to be prevailing average or median fees charged by physicians in the community.[9]

The agreements which a foundation enters into with insurers only concern the foundation endorsed insurance they underwrite. They provide that with respect to such plans the insurers agree to cover at least those medical services described in the foundation's minimum standards and to reimburse physicians for services rendered to patients insured under foundation endorsed health insurance plans in accordance with each physician's usual and customary fees charged for such services but not to exceed the maximum level of reimbursement established by the foundation.[10] A foundation reviews the medical necessity and appropriateness of treatment and, for some insured groups, also reviews utilization of hospital services. Following the medical review, it makes payment on claims for certain insured groups. In each instance, the foundation acts as an agent of an insurer who underwrites the health insurance plan.[11] Maricopa Foundation estimates it has saved patients and their in-

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[8]CR 57, para. 3.

[9]CR 57, para. 6.

[10]CR 54, paras. 21, 22.

[11]CR 25, Mitten Affidavit, paras. 2, 3.

surers over $6 million in medical fees.[12] Petitioner does not dispute that those reductions in medical costs have occurred.

Patients insured by foundation endorsed insurance plans need not go to foundation members for treatment. They are free to enlist the services of any physician of their choice.[13] In addition to free choice of physicians, the benefits to insured patients are the possibility of lower insurance premiums (due to the savings on fees paid), assurance that if a foundation member physician is used the insured will not have to pay any difference between what the physician bills and what the insurance will reimburse[14] and knowledge that the physician will be restrained from performing unnecessary treatment because a qualified physician will review the treatment performed to determine if it is medically necessary or appropriate.[15] Thus the foundations offer a health care service different from that which individual physicians or individual insurers could separately provide to the public.

Petitioner failed to adduce any evidence to support its price-fixing claims and erroneously relies solely upon the existence of Maricopa and Pima Foundations and their use of conversion factors and relative value schedules to establish maximum reimbursement levels for health insurance. A foundation uses relative value schedules and conversion factors to determine the maximum reimbursable levels of compensation for medical services

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[12]CR 106, Ex. E, preamble, at 3.

[13]CR 25, Mitten Affidavit, para. 4.

[14]CR 54, para. 2.

[15]CR 25, Mitten Affidavit, para. 2.

provided to patients insured under foundation endorsed health insurance plans.[16] All physicians are free to bill as they like and are treated the same whether or not they belong to a foundation. Any physician treating a patient covered by foundation endorsed insurance will be paid under the insurance in the same manner (*i.e.*, up to the foundation's maximum level of reimbursement). While foundation member physicians agree to accept that reimbursement by the insurer as payment in full and do not look to the patient to pay the difference between the physician's bill and the amount paid by the insurer, nonmember physicians are free to obtain from the patient the difference between the maximum reimbursement rate paid by the insurer and the amount of the bill directly from the patient.[17]

Arizona itself prepares and circulates both relative value schedules and conversion factors which are used to determine payments by Arizona to physicians for their services in, *inter alia*, workmen's compensation cases.[18] In many instances, Arizona's maximum reimbursement levels have been higher than those of the foundations.[19] Unlike the Arizona Industrial Commission, a foundation does not distribute relative value schedules to physicians. It only informs its members of the conversion factors it uses to calculate maximum reimbursement

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[16]CR 57, para. 2.

[17]*Id.*

[18]Brief of Defendant-Appellee Maricopa Foundation for Medical Care, dated September 12, 1979, Exhibit A (Supplemental Response of the State of Arizona to Defendant Maricopa Foundation for Medical Care's First Set of Interrogatories, Nos. 22 through 25, dated July 13, 1979).

[19]CR 62, para. 8.

levels for medical services to patients insured under foundation endorsed health insurance plans.[20]

Maricopa Foundation has a contract with Arizona to administer the Comprehensive Medical Dental Program for Foster Children. It makes payments to physicians under that program pursuant to the maximum allowable fee schedule of Arizona's Department of Economic Security, which provides for higher payments than those which would be made under Maricopa Foundation's own maximum levels of reimbursement to doctors providing services to patients insured under Maricopa Foundation endorsed health insurance plans.[21]

The evidence in the record does not establish that the foundations have exercised any control whatsoever over the prices physicians charge or dampened price competition among them. For example, the record shows Maricopa Foundation has not requested, urged or even suggested that a physician increase any fee or taken any action with respect to any doctor as a result of any fee billed, except to bring to the attention of the Arizona Board of Medical Examiners pursuant to Ariz. Rev. Stat. § 32-1451 (1976) those instances in which, in the opinion of its Board of Trustees, the fee charged was so excessive as to constitute unprofessional conduct.[22] Petitioner has presented no factual support for its assertion that the foundations' maximum levels of insurance reimburse-

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[20]CR 122, para. 37.

[21]CR 122, para. 83.

[22]CR 57, paras. 6, 9. Furthermore, Respondent Maricopa Foundation does not and never has taken any position with respect to the amount of fees a physician should bill any patient. CR 25, Mitten Affidavit, paras. 3, 4.

ment either are intended to be schedules of fees physicians should bill their patients or have operated as such. In fact, the maximum levels of reimbursement adopted by the Maricopa and Pima Foundations in 1977 are substantially different.[23] There is no evidence of any relationship between the fees physicians in Maricopa and Pima Counties charge their patients and the foundations' maximum reimbursement levels.[24]

Petitioner does not dispute that the Respondent foundations were established to provide residents of Pima and Maricopa Counties with a competitive alternative to utilization of closed panel prepaid health insurance plans.[25] The foundations' medical insurance programs provide a unique competitive alternative that directly promotes competition, with demonstrable benefits to insured patients. Petitioner has utterly failed to produce any evidence of uniformity of pricing or that physicians' prices changed as a result of any change in foundation maximum reimbursement levels.

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[23]Compare Exhibit B (Response of Maricopa Foundation for Medical Care to Plaintiff's First Request for Admissions and Interrogatories), para. 304 with Exhibit C (Response of Pima Foundation for Medical Care to Plaintiff's First Request for Admissions and Interrogatories), para. 413 in Brief of Defendant-Appellee Maricopa Foundation for Medical Care, dated September 12, 1979.

[24]While the foundations had not changed their maximum reimbursement levels since 1977, medical fees have, not surprisingly, increased. [CR 103, Mitten Affidavit, para. 3.] Therefore, it should be of no surprise to this Court that in 1979 eighty-five to ninety-five percent of physicians in Maricopa County billed at or above the maximum reimbursement levels adopted by Maricopa Foundation in 1977.

[25]The effect, if any, of the foundations on closed panel prepaid health insurance plans, commonly called Health Maintenance Organizations or HMOs, is not an issue in the proceedings for which Petitioner seeks review.

The District Court's Decision

The District Court's denial of Petitioner's motion for partial summary judgment that Respondents' conduct constituted a *per se* violation of section 1 of the Sherman Act, 15 U.S.C. § 1 (1977), followed a two-pronged analysis.[26] First, the District Court refused to apply blindly and mechanically the *per se* analysis demanded by Petitioner, recognizing that not all joint conduct constitutes *per se* violations. The court relied on *Continental T. V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977) and *General Glass Co. v. Globe Glass & Trim Co.* [1978-2] Trade Cas. (CCH) ¶ 62,231 (N.D. Ill. 1978).[27] The second prong of the opinion recognized that, since the case concerns the medical profession, the court should give Respondents the opportunity to show that the challenged conduct promoted improvement of professional services to the public. It based that decision upon *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 788 n. 17 (1975), *National Society of Professional Engineers v. United States*, 435 U.S. 679, 686 (1978), *Boddicker v. Arizona State Dental Association*, 549 F.2d 626, 632 (9th Cir.), *cert. denied*, 434 U.S. 825 (1977), and *Mackey v. National Football League*, 543 F.2d 606 (8th Cir. 1976). The District Court found Respondents' activities to be more properly tested by the

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[26]While the District Court denied defendants' motions to dismiss on the basis of the McCarran-Ferguson Act, 15 U.S.C. § 1012 (1977), that interlocutory determination has not been appealed as of yet.

[27]The District Court did not rule that *Continental T. V.* "established" a trend away from a *per se* approach, as claimed by Petitioner at p. 6. Furthermore, just prior to the District Court's decision, this Court decided Broadcast Music, Inc. v. Columbia Broadcasting System, Inc., 441 U.S. 1 (1979) which, as will be shown *infra*, supports the District Court's reasoning.

Rule of Reason standard than the rigid *per se* liability analysis which would follow from accepting Petitioner's characterization.[28] It ordered that Petitioner's motion for summary judgment be denied, but specifically allowed Petitioner to file a similar motion based on additional evidence. Petitioner accepted the District Court's invitation to elaborate upon the factual basis of its partial summary judgment motion by filing Plaintiff's Motion for Summary Judgment and Permanent Injunction, CR 105. That summary judgment motion purported to present facts adequate to establish Respondents' Sherman Act liability under a Rule of Reason standard. Applying the Rule of Reason standard in accordance with Petitioner's invitation, the District Court denied Petitioner's motion for summary judgment and permanent injunction, Minute Entry filed August 6, 1979. Subsequently, Petitioner brought an interlocutory appeal from the District Court's denial of Petitioner's first motion for partial summary judgment.

The Court of Appeals' Decision

The Ninth Circuit's decision affirmed the District Court's denial of summary judgement. It held that given the facts in the record on appeal, it could not rule that the District Court erred in denying either (a) Petitioner's requested preliminary injunction or (b) Petitioner's motion for partial summary judgement.

Judges Sneed and Kennedy looked to *Broadcast Music Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979) for guidance. Citing *Broadcast Music*, Judge Sneed noted "that whether to classify something as *'per*

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[28]The District Court did *not* intimate that *per se* analysis never applied to learned professions.

se price fixing' will often, but not *always*,be a simple matter."[29] He described the factual uncertainties in this action which include, *inter alia:*

> 1. The record reveals nothing about the actual effects of Respondents' activities on competition [Pet. App. A at 5];
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> 2. Petitioner's own maximum reimbursement levels for its workmen's compensation insurance program and foster children care program are higher than those of the foundations [*id.* at 3];
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> 3. The record does not establish that profits (from what Judge Sneed assumed to be a monopoly of medical care by doctors) have been increased by the challenged conduct[30] [*id.* at 6-7];
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> 4. No evidence had been adduced that the insurance carriers which use the foundations would supinely accept the alleged price-fixing which Petitioner assumes has raised the costs the insurance carriers pay [*id.* at 7]; and
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> 5. Nothing about the competitive interactions between the relevant economic actors, including Blue Cross and other health insurers, hospitals, and HMOs is revealed by the record [*id.* at 8-9].

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[29]Pet App. A at 8 (emphasis in original).

[30]The Court of Appeals stated that a rigid application of the *per se* rule would force it to accept the assumption that

> "the FMCs are but devices to enable the member doctors to capture a greater share of potential monopoly profit, which their monopoly power makes available, than otherwise would be possible. This is an assumption we are not prepared to make on the basis of the record before us." [Pet. App. A at 6-7.]

Judge Sneed concluded " [t]o affix the per se label to appellees' conduct is, however, once more to substitute an unsupported belief for proper proof."[31]

Contrary to Petitioner's assertion, Judges Sneed and Kennedy agree that the further evidence which would be adduced at trial might convince the trial court to classify the Respondents' challenged conduct as "price-fixing" which in future cases might be subject to a *per se* standard of liability. They simply found a *per se* analysis inappropriate at the summary judgment stage of these proceedings, noting that the professions had only recently been brought within section 1 of the Sherman Act[32] and that guidelines for professional conduct are still being written.

Judge Kennedy stated " [p]er se rules should be derived from considerations of economic impact in particular cases illustrating the category of prohibited acts and therefore a trial is appropriate to explore further the impact on competition of the challenged reimbursement schedules."[33]

REASONS FOR DENYING THE WRIT

I. *Petitioner's Claim that The Ninth Circuit Has Adopted a "Reasonableness of the Agreed-upon Price" Defense Is Erroneous.*

The Circuit Court's primary reason for affirming denial of summary judgment was the lack of evidence of any anti-competitive effects from the challenged conduct.

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[31]Pet. App. A at 8.

[32]Citing *Goldfarb*, 421 U.S. at 758-88 [Pet. App. A at 5-6].

[33]Pet. App. A at 13.

It did not rely on a reasonableness of price defense.[34] It stated:

> "The State of Arizona insists that [Respondents'] practice . . . constitutes an arrangement without any redeeming virtue that suppresses and destroys competition and is thus unreasonable per se. The difficulty with Arizona's position is that this record reveals nothing about the actual competitive effects of the challenged arrangement nor do the authorities, primary or secondary, afford assurance concerning its competitive impacts. In truth, we know very little about the impact of this and many other arrangements within the health care industry. This alone should make us reluctant to invoke a per se rule with respect to the challenged arrangement."[35]

A careful reading in their entirety of the majority opinions affirming the denial of summary judgment inevitably leads to the conclusion that at this stage in the proceedings insufficient evidence has been introduced by Petitioner to convince either the District Court or the Circuit Court that the conduct at issue should simply be called "price-fixing." The Ninth Circuit adopted no "rea-

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[34]Petitioner's citation of McLain v. Real Estate Bd. of New Orleans, Inc., 444 U.S. 232 (1980) and United States v. United States Gypsum Co., 438 U.S. 422 (1978) is irrelevant. Contrary to Petitioner's assertion, the Ninth Circuit did not ignore the rule that, "in a civil action under the Sherman Act, liability may be established by proof of either an unlawful purpose or an anticompetitive effect." Petition at 10. The Ninth Circuit properly found the undisputed facts which had been offered in support of Petitioner's summary judgment motion to be insufficient to summarily determine in Petitioner's favor that Respondents were subject to either "unlawful purpose" or "anticompetitive effect" liability.

[35]Pet. App. A at 5.

sonableness of price defense" nor did it eliminate the possibility that after a full trial a *per se* analysis might be applied to similar conduct in the future if it were found anticompetitive and unlawful.

The Ninth Circuit's refusal to affix the horizontal price-fixing label to the Respondents' conduct on a motion for summary judgment conformed to the analysis mandated by *Broadcast Music*, where this Court held that the Rule of Reason should govern the determination of the legality of the blanket licensing practice at issue (which had been held to be *per se* illegal price-fixing by the Court of Appeals).

> "To the Court of Appeals and CBS, the blanket license involves 'price fixing' in the literal sense: the composers and publishing houses have joined together into an organization that sets its price for the blanket license itself. But this is not a question simply of determining whether two or more potential competitors have literally 'fixed' a 'price.' As generally used in the antitrust field, 'price fixing' is a shorthand way of describing certain categories of business behavior to which the *per se* rule has been held applicable. The Court of Appeals' literal approach does not alone establish that this particular practice is one of those types or that it is 'plainly anticompetitive' and very likely without 'redeeming virtue.' Literalness is overly simplistic and often overbroad . . . .
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> Consequently, [citation omitted] '[i]t is only after considerable experience with certain business relationships that courts classify them as *per se* violations . . . .' "[36]

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[36]441 U.S. at 8-9.

This Court observed that while the *per se* rule "is a valid and useful tool of antitrust policy and enforcement," courts must not be too quick to seize upon it as a replacement for reasoned analysis of challenged practices: "[E]asy labels do not always supply ready answers."[37] This Court concluded that "[n]ot all arrangements among actual or potential competitors that have an impact on price are *per se* violations of the Sherman Act or even unreasonable restraints."[38]

The foundation endorsed insurance plans are, it is respectfully submitted, subject to the same type of analysis as the blanket licenses in the *Broadcast Music* case. As in that case, Petitioner has failed in this action to establish any agreement by competitors as to prices they will sell at on an individual basis. A foundation endorsed insurance plan is a health care service different from that which any individual physician or individual insurer could separately provide the public. In the complex health care industry, one in which the courts have not amassed considerable experience, the Ninth Circuit correctly refused to pin the "easy label" on the Respondents' conduct when Petitioner moved for summary judgment.

Broadcast Music is the most recent in a line of cases including *Continental T. V.*, in which this Court condemned the precipitous application of *per se* rules to all antitrust cases. This Court noted in overruling *United States v. Arnold, Schwinn & Co.*, 388 U.S. 365 (1967), that it "was an abrupt and largely unexplained departure from *White Motor Co. v. United States*, 372 U.S. 253, 83 S. Ct. 696, 9 L.Ed.2d 738 (1963), where only four years

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[37] *Id.* at 8.

[38] *Id.* at 23.

earlier this Court had refused to endorse a *per se* rule for vertical restrictions."[39]

In rejecting the truncated *per se* analysis employed in *Schwinn*, this Court plainly insisted that courts focus on the substantive orientation of the antitrust laws in analyzing particular cases, declaring: "'Realities must dominate the judgment. . . . The Anti-Trust Act aims at substance.'"[40] This Court emphasized that "[*p*]*er se* rules of illegality are appropriate only when they relate to conduct that is manifestly anti-competitive,"[41] and warned: "[W]e . . . make clear that departure from the rule of reason standard must be based upon demonstrable economic effect rather than—as in *Schwinn*—upon formalistic line drawing."[42] Petitioner asks this Court to disregard these prior admonitions by affixing conclusory labels to the foundations' activities and blindly applying the *per se* rule with no showing of "demonstrable economic effect."

Finally, as this Court noted in *White Motor Co. v. United States*, 372 U.S. 253, 263 (1963), (and reiterated, in substance, in *Broadcast Music*, 441 U.S. at 10, 16), "We need to know more than we do about the actual impact of these arrangements on competition to decide whether they have a 'pernicious effect on competition and lack . . . any redeeming virtue' [citation omitted] and therefore should be classified as *per se* violations of the Sherman Act." Similarly here, there has been too little

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[39]*Continental T. V.*, 433 U.S. at 47.

[40]*Id.* at 47, *quoting Appalachian Coals, Inc. v. United States*, 288 U.S. 344, 360 (1933).

[41]433 U.S. at 49-50.

[42]*Id.* at 58-59.

antitrust experience with the medical foundation concept of offering a lower cost alternative health insurance plan to blindly apply, as Petitioner would, a rigid *per se* analysis in the present case and the lower courts were correct in refusing to do so.

II. *Petitioner's Claim that the Ninth Circuit Created a New Burdensome or Impractical Standard of Proof is Erroneous.*

Notwithstanding Petitioner's claims, the Court of Appeals in no way required Petitioner to meet a new or unreasonably burdensome standard of proof. It only held that more evidence needed to be in the record before the trial court could determine if the Respondents' conduct should be found to be illegal price-fixing. Numerous decisions of this Court make it clear that not all horizontal agreements allegedly affecting price are *per se* unlawful. As discussed above, this Court rejected the simplistic approach to antitrust analysis favored by Petitioners in the *Broadcast Music* decision.

Catalano, Inc. v. Target Sales, Inc., 100 S. Ct 1925 (1980), cited extensively by Petitioners, is irrelevant to this action.[43] The *Catalano* case involved the question of characterization of an agreement among wholesalers to fix credit terms in which this Court held "credit terms must be characterized as an inseparable part of the

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[43]Respondents note in passing that the Petitioner appears to attempt to impugn the authority of the Ninth Circuit's decision in this action by implying that the reasoning of Judge Sneed should be rejected simply because *Catalano*, a case on which his decision in this action nowhere relied, was overruled. Such reasoning is, of course, spurious and improper.

price."[44] This Court ruled that the Ninth Circuit had erred in not making that characterization. In observing that "It has long been settled that an agreement to fix prices is unlawful *per se*. It is no excuse that the prices fixed are themselves reasonable."[45] this Court cited *United States v. Trenton Potteries Co., 273* U.S. 392, 397-98 (1927); *United States v. Trans-Missouri Freight Association,* 166 U.S. 290, 340-41 (1897); and *United States v. Socony-Vacuum Oil Co.,* 310 U.S. 150 (1940). In none of those cases did plaintiff prevail on a motion for summary judgment. In each instance, except the *Trans-Missouri Freight* decision, which only remanded the action for further proceedings after the complaint had been dismissed, a determination that the defendant's conduct was unlawful under the Sherman Act took place. But that determination was only made after completion of discovery and a trial on the merits. The same is true of *Sugar Institute v. United States,* 297 U.S. 553 (1936), *National Society of Professional Engineers v. United States,* 435 U.S. 679 (1978), *Federal Trade Commission v. Cement Institute,* 333 U.S. 683 (1948), and the other cases cited by this Court in support of its decision in *Catalano.*

This Court stated in *Catalano*: "when a particular concerted activity entails an obvious risk of anticompetitive impact with no apparent potentially redeeming value, the fact that a practice may turn out to be harmless in a particular set of circumstances will not prevent its being declared unlawful *per se*."[46] Note 8 to that decision made it clear that "Respondents nowhere suggest a pro-

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[44]100 S. Ct. at 1925.

[45]*Id.* at 1927.

[46]100 S. Ct. at 1928.

competitive justification for a horizontal agreement to fix credit. Their argument is confined to disputing that settled case law establishes that such an agreement is unlawful on its face."[47]

Unlike the situation in *Catalano*, Respondents in this action have suggested and argued below the procompetitive justification of offering an alternative to closed panel prepaid medical plans with foundation endorsed insurance, something which individual physicians could not separately attempt to do. Respondents further have suggested as a procompetitive justification that the effect of the foundation medical plans is to decrease the cost of medical service rather than to increase its cost and that this is done without any demonstrable effect upon the prices which physicians bill their patients. Additionally, the *Catalano* Court dealt with acts in a purely commercial industry. In contrast, in this action the challenged conduct concerns pricing in the medical profession. *See Veizaga v. National Board for Respiratory Therapy*, [1977-1] Trade Cas. (CCH) ¶61,274 (N.D. Ill. 1977) where the court denied plaintiff's motion for summary judgment, holding that determination of whether the questioned conduct was professional or commercial could not be made before trial.

The antitrust laws were not intended to straightjacket experimentation in fields such as the professions, not traditionally subject to antitrust scrutiny. In *Goldfarb* this Court went out of its way to state:

> "The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that

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[47] *Id.* at 1927.

> particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently. We intimate no view on any other situation than the one with which we are confronted today."[48]

In *National Society of Professional Engineers*, this Court reiterated that "certain practices by members of a learned profession might survive scrutiny under the Rule of Reason even though they would be viewed as a violation of the Sherman Act in another context."[49] The decision then quoted in its entirety note 17 from *Goldfarb*.

In reality, Petitioner attempts to avoid *any* standard of proof, not merely a burdensome one. It would have this Court make a facile determination that Respondents' conduct is "price-fixing" and thus *per se* illegal, when both the District Court and the Ninth Circuit have found the evidence insufficient at this stage in the proceedings to support that determination.

Petitioner argues that the Ninth Circuit promulgated an impractical and unworkable standard, yet the majority opinion placed no added burdens on district courts. The Circuit Court recognized that in considering a complex and novel factual situation involving a profes-

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[48]421 U.S. at 788 n.17.

[49]435 U.S. at 686.

sion, summary judgment of liability based upon unreasoning application of *per se* rules would be unwise, when the court has not had the benefit of enough evidence to understand the consequences of the conduct which is challenged. The Ninth Circuit's decision merely requires Petitioner to prove that the Respondents' activities constituted anticompetitive price-fixing instead of assuming that as a theoretical matter in a factual vacuum. This is no greater an obstacle than has been overcome time and time again when a plaintiff challenges for the first time activities asserted to be illegally anticompetitive.

III. *Petitioner's Claim that a Conflict Has Been Created Between the Circuit Courts of Appeals Regarding the Per Se Illegality of Horizontal Price-Fixing Is Erroneous.*

Since the Ninth Circuit determined that it would not be proper to characterize Respondents' conduct as "price-fixing" on the record before it, it did not have to decide if horizontal price-fixing agreements that establish maximum prices constitute a *per se* violation. Unlike the situation in *Goldfarb*, where a mandatory minimum fee schedule with respect to prices to be charged for legal services was found to violate section 1, there is no proof of uniform pricing in this action. This Court stated in the *Goldfarb* decision:

> "A purely advisory fee schedule issued to provide guidelines, or an exchange of price information without a showing of an actual restraint of trade, would present us with a different question. . . ."[50]

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[50]421 U.S. at 781.

Thus, the only discussion of application of the *per se* rule to horizontal agreements fixing maximum prices in Judge Sneed's opinion is in footnote 4, where he states "[i]t is arguable that this case does not present the issue for our decision."[51] Judge Kennedy was silent on the issue.

The majority's determination was that the challenged conduct should not be characterized as price-fixing; not that horizontal maximum price-fixing is not a *per se* violation. Thus, the Ninth Circuit's opinion does not conflict with this Court's rulings in *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons*, 340 U.S. 211, 213 (1951), *Albrecht v. Herald Co.*, 390 U.S. 145, 153 (1968), and *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980) that maximum resale price-fixing is unlawful. Since the Circuit Court affirmed the denial of partial summary judgment without having to decide whether horizontal maximum price-fixing agreements should be *per se* violations, this Court has no conflict to resolve.

IV. *Petitioner's Claim That the Ninth Circuit Adopted Special Standard for Doctors Is Erroneous.*

The Ninth Circuit's decision follows logically from decisions of this Court. No "special standard for doctors" was created or even implied. The Court of Appeals followed *Goldfarb* and *National Society of Professional Engineers* which recognize that some degree of factual investigation concerning impact on competition and possible benefit to the public should be conducted before holding

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[51]Pet. App. A at 7.

a profession's activities to be *per se* price-fixing when they are subject to antitrust scrutiny for the first time.

The Ninth Circuit applied the "effect on competition" test expounded by this Court throughout the years, and recently restated in *National Society of Professional Engineers*, 435 U.S. at 690. Therefore, rather than adopting a radical special standard of liability for doctors as Petitioner claims, the Ninth Circuit cautiously followed the admonitions stated in recent decisions of this Court, admonitions especially appropriate to the denial, based upon the present insufficiency of the evidence, of a pre-trial motion for partial summary judgment on the issue of Respondents' antitrust liability based solely on Petitioner's characterization of Respondents' conduct.

Furthermore, no conflict exists between the circuit courts of appeal over a so-called doctors' exemption (or even the more general learned professions' exemption, a specter raised by Petitioner to create the appearance of conflict). The Ninth Circuit's determination that the evidence adduced at this point in the proceedings is insufficient to reverse the District Court's refusal to summarily adjudge a *per se* violation of the antitrust laws in view of the nature of the challenged conduct, the complexity of the industry and the involvement of a profession, conforms with the procedure followed in the cases cited by Petitioner. *See Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, [1980-2] Trade Cas. (CCH) ¶63,395 (4th Cir. 1980)

The courts in those cases followed this same cautious path, determining whether there was *per se* liability only after the facts were completely adduced. *United States v. Utah Pharmaceutical Association*, 201 F. Supp. 29 (D. Utah), *aff'd*, 371 U.S. 24 (1962) (finding *per se* liability after fulsome discovery, stipulations and trial);

Feminist Women's Health Center, Inc. v. Mohammad, 586 F.2d 530 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979) (summary judgment for defendants found not proper because factual analysis showed that *per se* liability might, given more proof, apply); *United States v. National Society of Professional Engineers*, 555 F.2d 978, 980 (D.C. Cir. 1977), *aff'd*, 435 US 679 (1978) (applying *per se* liability only after "extensive discovery and trial"; *see also* this Court's analysis testing the Circuit Court's decision under the Rule of Reason); *Veizaga*, [1977-1] Trade Cas. (CCH) at 70,870 (the question of whether activities were subject to *per se* analysis was one of fact to be decided at trial and not on summary judgment.)[52] Since the Ninth Circuit followed the same approach in the instant litigation, no conflict exists for this Court to resolve.[53]

In summary, there is no special or important reason which would justify this Court's exercise of its discretion to grant the requested writ. The Ninth Circuit's decision created no new standard to apply to either hor-

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[52]The court in United States v. Texas State Bd. of Pub. Accountancy, 464 F. Supp. 400 (W.D. Tex. 1978), *aff'd*, 592 F.2d 919 (5th Cir.), *cert. denied*, 444 U.S. 925 (1979) found itself in the enviable position of facing a rule of a professional board virtually identical to that in *National Soc'y of Prof'l Eng'rs*. Thus, no factual analysis was necessary in the light of this Court's recent decision that such activity is properly characterized as price-fixing.

[53]Petitioner further posits that the Circuit Court's decision has generated some undefined uncertainty which must now be resolved by this Court. However, nowhere is this uncertainty given tangible meaning; it simply does not exist. The Ninth Circuit created no new "doctors' exemption" doctrine; it followed this Court's directives and it conformed to the manner in which the other circuits resolve whether the *per se* price-fixing characterization should be attached to questioned conduct. In any case, whatever "uncertainty" might conceivably exist will surely be resolved at trial.

izontal price-fixing agreements or doctors. The Circuit Court simply recognized that insufficient evidence has been brought forth to support Petitioner's characterization of Respondents' conduct as price-fixing which is a *per se* violation; thus, the matter should be tried before the liability issue can be decided.

This approach to the characterization of conduct as a *per se* violation comports with the rulings of this Court, creates no conflicts whatsoever between the rulings of the circuits, creates no unworkable standard burdensome to prosecutorial efforts and has not created such an uncertainty that might require this Court's attention on a writ of certiorari.

Respondents respectfully suggest that this litigation be permitted to follow its natural course and proceed to trial. At trial, sufficient evidence will be introduced to enable the trial court to determine if Respondents' activities present the anticompetitive dangers claimed by Petitioner and thus constitute "price-fixing," or if, as Respondents claim, the challenged conduct is beneficial to the public and has resulted in large savings in medical insurance premium costs without increasing medical fees.

CONCLUSION

Respondents respectfully ask this Court to deny the petition for writ of certiorari to the United States Court of Appeals for the Ninth Circuit for the reasons set forth in this Brief.

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